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**NATIONAL ADVISORY COMMITTEE ON RURAL
HEALTH AND HUMAN SERVICES**

**MODERNIZING RURAL HEALTH CLINIC
PROVISIONS**

POLICY BRIEF AND RECOMMENDATIONS

DECEMBER 2017

EDITORIAL NOTE

In September 2017, the National Advisory Committee on Rural Health and Human Services (hereinafter referred to as “the Committee”) met in Boise, Idaho. During this meeting, the Committee focused on ways to modernize the Rural Health Clinic (RHC) provisions. The statutory authorization for RHCs is 30 years old and members expressed concerns the current regulatory and statutory foundation of RHCs is not well aligned to meet today’s health care needs and those in the future. While in Boise, the Committee heard from federal and state health and human service officials and RHC providers.

ACKNOWLEDGEMENTS

The Committee would like to give thanks and acknowledgement to those whose participation helped make this brief possible. The Committee would like to thank North Canyon Medical Center, North Canyon Family Physicians, Associates in Family Practice, Shoshone Family Medical Center, and Power County Hospital District for sharing their experiences as rural health clinics. The Committee would also like to acknowledge the research and policy background provided by Bill Finerfrock (National Association of Rural Health Clinics), Teresa Cumpton (Centers for Medicare & Medicaid Services), John Gale (Maine Rural Health Research Center), and Wakina Scott (Federal Office of Rural Health Policy.)

Special thanks to Mary Sheridan, who served as the chair of the rural health clinic subcommittee. Other members of this subcommittee include Kathleen Dalton, Carolyn Emanuel-McClain, Kelley Evans, Carolyn Montoya, Chester Robinson, and Mary Kate Rolf.

Finally, we would like to acknowledge the work of Victoria Maloch on behalf of the committee.

RECOMMENDATIONS

Payment Options

1. The Committee recommends the Secretary work with Congress to obtain authority to reexamine and pursue a change in the statute^a to adjust the payment cap for RHCs. In doing so, the Committee urges the creation of a formula for payments that ties payment cap increases to the current average cost per visit for RHCs currently under the cap.

Program Support

2. The Committee recommends the Secretary work with Congress to provide grants to State Offices of Rural Health to support a state program that would provide technical assistance on quality reporting and other services to support the transition of RHCs to value-based care.

Services

3. The Committee recommends the Secretary work with Congress to obtain authority to allow RHCs to be distant site providers for telehealth services under Medicare.
4. The Committee recommends the Secretary work with Congress to obtain authority to allow all RHC (non-physician) providers to order hospice and home health services and also allow RHC providers to be attending clinicians for hospice services.

Workforce

5. The Committee recommends the Secretary work with Congress to obtain authority to allow masters trained behavioral health providers (e.g., licensed professional counselors, mental health counselors, or marital and family therapists) to be RHC practitioners for purposes of Medicare reimbursement if they are licensed to provide those services in their state.

Lab Requirements

6. The Committee recommends the Secretary publish a Request for Information to RHC providers on current RHC laboratory needs. Based on this information, the Committee recommends the Secretary use the authority granted in Public Law 95-210 to review and modernize lab requirements to reduce regulatory burden and allow flexibility in requirements to reflect patient population services.

^a Current payment cap structure established in the Omnibus Budget Reconciliation Act of 1987 by amending SSA Sec. 1833(f)(2).

INTRODUCTION

More than 4,100 Rural Health Clinics (RHC) in 44 states^b make up a significant portion of the rural health care infrastructure. The patient populations served by RHCs include a high proportion of rural elderly and poor.¹ RHCs allow for greater access to primary health care that can focus on wellness, health promotion, and disease prevention, as well as improve rural residents' ability to manage the illnesses and chronic conditions that cause such high human and economic costs. In addition, RHCs are increasingly looked upon as a key part of the rural safety net based, in part, on the requirement they be located in rural areas designated as underserved.² Similar to rural hospitals, RHCs have a payer mix heavily dependent on Medicare.³ Medicaid beneficiaries also make up a substantial portion of RHC patients.⁴ While RHCs are not required to provide services on a sliding fee scale, many do. A recent study showed 86 percent of independent RHCs offer free care, sliding fee scales, or both.⁵

With increased focus on value-based care in the Medicare and Medicaid programs, there are growing concerns about the viability of RHCs and the extent to which RHCs are improving access to care. While there has been a significant growth in the number of RHCs over the past three decades, RHCs continue to face challenges related to services provided, their payment structure, and workforce. These providers play an important role in ensuring access to care in rural communities, particularly for Medicare and Medicaid beneficiaries, but as health care evolves the Committee believes these clinics are increasingly being limited by an outdated regulatory structure.

LEGISLATIVE HISTORY

The Rural Health Clinic Services Act (RHC Act) of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare and Medicaid beneficiaries in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA). At the time, NPs and PAs were not eligible for reimbursement. Given access problems across rural America, the creation of the RHC was seen as a way to address access and workforce challenges by taking advantage of non-physician primary care providers. Over the next two decades, the RHC setting, and subsequently Federally Qualified Health Centers (FQHC), provided a test bed for demonstrating the impact of expanding the primary care workforce. With the model a proven success, the Balanced Budget Act (BBA) of 1997⁶ authorized direct reimbursement for NPs and expanded flexibility for PAs.

Meanwhile, during the 1990s, because of several legislative actions that changed the RHC payment methodology and added additional practitioners, there was a significant growth in the number of RHCs across the country. In fact, the number of RHCs grew by over 650 percent from 1990 (314 RHCs) through October 1995 (2,350 RHCs).⁷ This growth prompted some concern from policymakers, which led to payment caps for some provider-based RHCs^c and RHCs losing their

^b As of May 2017, six states -- Alaska, Connecticut, Delaware, Maryland, New Jersey, and Rhode Island -- had no RHCs in operation. A full list of certified RHCs can be access on the CMS RHC Webpage at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/rhclistbyprovidername.pdf>.

^c The cap was put in place for provider-based RHCs of hospitals with 50 or more beds. Independent RHCs already had a payment cap through the original legislation.

status as a certified RHC.⁸ HHS has attempted to address some of these concerns in rulemaking but the provisions were never finalized and there has been no Congressional or stakeholder pressure to revisit the issue.⁹

STRUCTURE AND REQUIREMENTS

Organizational Structure

RHCs are either independent (i.e., freestanding) or provider-based, meaning owned and operated as an integral and subordinate part of a hospital, skilled nursing facility, or home health agency (HHA) participating in the Medicare program. While skilled nursing facilities and HHAs can own an RHC, few do. Hospitals can own and operate provider-based as well as independent RHCs. Per regulation, provider-based RHCs are not considered departments and must be financially and operationally integrated units of the parent entity. Today, approximately 57 percent of RHCs are provider-based and 43 percent are independent. This is a shift in the types of RHCs as there were previously more independent RHCs in comparison to provider-based RHCs.¹⁰ RHCs can be gender- or age-specific (e.g., pediatric-only, adult-only, or Ob-Gyn) as long as the majority of care provided is primary care. Finally, RHCs can be public, nonprofit, or for-profit.

Payment Options

Payment for outpatient primary care services furnished to Medicare patients by an RHC is made by means of a bundled or average per-visit payment for a defined package of RHC core services. This bundled payment is referred to as an all-inclusive rate (AIR). The AIR covers the cost of professional (including physician, nurse practitioner, physician's assistant, midwife, and nursing care) and other services and supplies provided during a clinic visit; visiting nurse services to the homebound; and/or clinical psychologist and social worker services as well as including services and supplies incident to those services. When Congress passed the RHC Act in the mid-1970s, it authorized cost-based payments for RHC services up to a statutorily prescribed cap. However, this cap was originally authorized only for independent RHCs. In the BBA of 1997, Congress extended the cap to provider-based RHCs in rural hospitals with 50 or more beds, in part, due to the growth in the number of RHCs. Provider-based RHCs that are part of a hospital with fewer than 50 beds, including critical access hospitals (CAH), are not subject to a payment cap. RHCs subject to the payment cap are paid at the lower of the adjusted costs per visit or the payment cap.

Between 1977 and 1988, Congress twice raised the RHC cap via legislative initiatives. Beginning in 1988, Congress authorized annual RHC cap adjustments based on the Medicare Economic Index (MEI). The first rate using this method was set at \$46 per visit.¹¹ As a result of medical inflation, the RHC cap for 2017 is \$82.30 per visit. In general, the Medicare Administrative Contractor (MAC) calculates the AIR for an RHC by dividing total allowable costs by the total number of visits for all patients. In addition to the payment cap, productivity standards help determine the average cost per patient for Medicare reimbursement in RHCs. The current productivity standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent non-physician practitioner (NP, PA, or certified nurse midwife (CNM)). However, the MAC has the discretion to make an exception to the productivity standards.

Services

In addition to general primary care, RHC practitioners provide other services such as influenza, pneumococcal, hepatitis B vaccinations, an initial preventive physical exam, an annual wellness visit, Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), and transitional care management services.¹² These services can all be provided as part of the RHC's all-inclusive rate. As of January 1, 2016, RHCs can also bill for chronic care management services. Such service is paid at the Physician Fee Schedule national average non-facility payment rate, which is about \$42 in 2017. RHCs can also receive payment for facilitating telehealth services (i.e., linking a patient to distant specialist) as the originating site, but must carve them out of the cost report and provide them as a separate billable service under Medicare Part B Physician Fee Schedule apart from any RHC services. This is done to prevent commingling and the arrangements are subject to a review during CMS surveys. RHCs are not allowed, however, to provide telehealth services (i.e., serve as the distant site).

Workforce

In addition to meeting location requirements for certification, an RHC must also employ at least one NP or PA. An NP, PA, and/or CNM must work at least 50 percent of the scheduled RHC operating hours. Further, an RHC must be "under the medical direction of a physician" who is a doctor of medicine (MD) or doctor of osteopathic medicine (DO), but the physician's level of direct patient care may be minimal.¹³ RHC practitioners can include a physician, PA, NP, CNM, doctoral-level clinical psychologist (CP), and a master-level clinical social worker (CSW). These are the only practitioners that can provide services at an RHC in order for the RHC to receive the cost-based all-inclusive payment rate.

Lab Requirements

RHCs are required to directly furnish routine diagnostic and laboratory services and have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC. Laboratory tests required to be furnished on-site are:¹⁴

- Chemical examination of urine by stick or tablet method or both
- Hemoglobin or hematocrit
- Blood sugar
- Examination of stool specimens for occult blood
- Pregnancy tests
- Primary culturing for transmittal to a certified laboratory

Location Requirements

RHCs receive certification from CMS for participation in the Medicare and Medicaid programs.¹⁵ To be certified as an RHC, a clinic must be located in a Census-designated, non-urbanized area and in a health professional shortage area (HPSAs) (geographic or population HPSA), medically underserved area (MUA),^d or governor-designated MUA. Further, the shortage area or MUA must have been designated or renewed within the previous four years.

^d This does not include the medically underserved population (MUP) designation.

RHCs AND FQHCs

RHCs, FQHCs, and private primary care providers all play a role in ensuring access to primary care services in rural America. FQHCs are federal grantees and enjoy the enhanced support of a larger grant program. RHCs are a designation conferred by the Centers for Medicare and Medicaid Services, which stipulates reimbursement for the various types of RHCs. Over 4,100 RHCs and 10,000 FQHC sites deliver primary care to communities across the country.¹⁶ RHCs and FQHCs both play essential roles in the health care safety net, securing access to health care in rural areas across the country. While FQHCs serve both urban and rural areas, RHCs are only allowed in rural areas. Additionally, there are significant differences in the overall structure, location requirements, services provided, and payments for RHCs and FQHCs.

In general, RHCs have fewer requirements regarding specific services they must offer, but have additional requirements related to location and staffing designed to ensure access to care in rural areas. On the other hand, FQHC service requirements ensure access to a more comprehensive range of health care and support services in FQHCs, but are arguably more difficult (i.e., resource-intensive) to implement and maintain. However, FQHC status typically comes with Health Resources and Services Administration (HRSA) grant funding and typically higher Medicare and Medicaid payment rates.

For Medicare reimbursement, both RHCs and FQHCs do not receive payment through the physician fee schedule like other comparable providers of outpatient, Medicare Part B services. Historically, this has allowed RHCs and FQHCs to provide services that were not typically eligible for Part B reimbursement –services such as dental health care and transportation at FQHCs. Instead, CMS pays an AIR to RHCs and a prospective payment for FQHCs – bundled rates that provide consistency, stability, and simplicity for RHC and FQHC payment.

The Affordable Care Act of 2010 revised FQHC payment structure, putting in place a prospective payment system (PPS) which began in 2014. RHC payment remains based on the original payment system from 1988, although certain RHCs (i.e., independent RHCs and provider-based RHCs owned by hospitals of 50 or more beds) are also subject to a cap. Today, this can equate to an \$81 difference in payment between a visit to an FQHC and certain RHCs subject to a payment cap. For example, in 2017 the RHC cap is \$82.30, whereas FQHC PPS for the same basic service is \$163.49. The gap is less for provider-based RHCs at hospitals with less than 50 beds. On average, adjusted cost per visit for RHCs subject to the cap is greater than their payment for a visit (see Table 1). Unlike the RHC AIR, the FQHCs are paid 80 percent of the lesser of their charges based on the FQHC payment codes or the FQHC PPS rate. The coinsurance for Medicare patients of RHCs is 20 percent of total charges, except for certain preventive services (in other words, Medicare pays the RHC 80 percent of the AIR for each RHC visit). There is no Part B deductible in FQHCs for FQHC-covered services.

Table 1: Mean Adjusted Cost per Visit for RHCs

RHC Characteristics (n)		n	Mean ACPV	2017 Cap	Shortfall
Independent RHCs		1,235	\$112.12	\$82.30	\$29.82
Size	Small	324	\$126.40	\$82.30	\$44.10
	Medium	408	\$106.83	\$82.30	\$24.53
	Large	402	\$106.01	\$82.30	\$23.71
	Extra-Large	101	\$112.03	\$82.30	\$29.73
Ownership	Private/for profit	883	\$103.96	\$82.30	\$21.66
	Non-profit/publicly owned	296	\$130.70	\$82.30	\$48.40
Provider-Based RHCs		1,904	\$176.73	\$82.30	\$94.93
Size	Small	650	\$186.64	\$82.30	\$104.34
	Medium	571	\$170.02	\$82.30	\$87.72
	Large	571	\$171.02	\$82.30	\$88.72
	Extra-Large	112	\$182.52	\$82.30	\$100.22
Subject to Cap?	Yes	421	\$163.38	\$82.30	\$81.08
	No	1,254	\$181.00	N/A	N/A
Attached to CAH?	Yes	1,026	\$182.06	N/A	N/A
	No	778	\$168.54	Varies	Varies

Source: Analysis of cost reports completed by the Maine Rural Health Research Center for the National Advisory Committee on Rural Health and Human Services (October 2017)

The Maine Rural Health Research Center analyzed Medicare Cost Report data to determine the adjusted cost per visit for RHCs. The data analyzed was from cost reports for the period ending 12/31/2014. To help distinguish between RHCs, they were grouped by clinic size: small (1 – 4,342 visits), medium (4,343 – 9,324 visits), large (9,325 – 28,040 visits), and extra-large (28,041 or more visits). Independent RHCs were grouped by ownership (private/for profit or non-profit/publicly owned). Provider-based RHCs were grouped by association with a CAH and whether they were subject to the reimbursement cap (clinics with 50 or more beds are capped).

While there is increased interest in maintaining access to primary care through RHCs at both the federal and state level, special consideration and focus is needed for some of the ongoing and most recent challenges RHCs face, which could ultimately be harmful to the sustainability of RHCs and their ability to provide access for Medicare and Medicaid patients. Addressing such challenges through legislation, regulations, or sub-regulatory policies could not only help to modernize RHC provisions, but could also lead to increased access to health care and improved health care outcomes for rural beneficiaries.

RECOMMENDATIONS

The following recommendations to modernize Rural Health Clinic provisions are listed in order of precedence as determined by the Committee.

Payment Options

The Committee is concerned about the viability of RHCs under the current payment cap. The limitation for independent, freestanding RHCs and provider-based RHCs of hospitals with 50 or more beds does not cover the actual cost of providing care. RHC staff presenting to the Committee noted that the reimbursement cap as updated by the MEI has not kept pace with the cost of providing services. RHCs subject to the payment cap reported adjusted costs per visit that exceeded the reimbursement cap by \$25.00 to \$81.00 depending on size and hospital ownership.

Further, the underlying RHC rate is based on an outdated methodology for determining the value of services. FQHCs, which previously were paid on a similar methodology, have since been authorized by Congress to use a prospective payment system that appears to better align services and costs.

Recommendation 1: The Committee recommends the Secretary work with Congress to obtain authority to reexamine and pursue a change in the statute^e to adjust the payment cap for RHCs. In doing so, the Committee urges the creation of a formula for payments that ties payment cap increases to the current average cost per visit for RHCs currently under the cap.

Program Support

A risk for both FQHCs and RHCs is that, in the long-term, they will not be able to participate effectively in a redesigned health care payment and delivery system focused on quality and value as a determinant of payment. More specifically, RHCs and FQHCs may be unprepared to take on the risk required under new payment models or may not be seen as attractive partners to larger groups like accountable care organizations (ACOs). FQHCs may be further along on responding to these sort of emerging challenges because of support they receive as a result of being HRSA grantees under Section 330 of the Public Health Service Act. HRSA has taken important steps to emphasize quality reporting CHCs and using that data to improve patient outcomes.

There is no comparable support available to RHCs. The Committee notes that small rural hospitals were facing similar challenges in the early 2000s until revisions to the Rural Hospital Flexibility Grant Program and the Small Rural Hospital Improvement program focused program resources on quality reporting and performance improvement. Those HRSA grants work through State Offices of Rural Health to provide support and technical assistance. RHCs lack the administrative capacity to respond to emerging changes in the health care environment.

Recommendation 2: The Committee recommends the Secretary work with Congress to provide grants to State Offices of Rural Health to support a state program that would provide technical assistance on quality reporting and other services to support the transition of RHCs to value-based care.

Services

While RHCs can currently serve as originating sites (where the patients are located) for telehealth, they are not allowed to serve as the distant site (providing professional services) for telehealth

^e Current payment cap structure established in the Omnibus Budget Reconciliation Act of 1987 by amending SSA Sec. 1833(f)(2).

services under Medicare. Additionally, RHC non-physician providers are not allowed to order hospice and home health services or be attending clinicians for hospice services.

Recommendation 3: The Committee recommends the Secretary work with Congress to obtain authority to allow RHCs to be distant site providers for telehealth services under Medicare.

Recommendation 4: The Committee recommends the Secretary work with Congress to obtain authority to allow all RHC (non-physician) providers to order hospice and home health services and also allow RHC providers to be attending clinicians for hospice services in hospice shortage service areas.

Workforce

While RHC provisions were designed, in part, to increase access to health care services provided by PAs and NPs, such provisions could be reconsidered to allow for greater flexibility in the types of providers that could provide and bill Medicare for RHC services at the AIR (versus incident to a currently approved RHC practitioner). For example, providers such as masters trained behavioral health providers (such as licensed professional counselors, mental health counselors, or marital and family therapists) operating within the scope of their state licenses and reimbursable by state Medicaid programs could help increase access to mental health services for Medicare beneficiaries through RHCs.

Recommendation 5: The Committee recommends the Secretary work with Congress to obtain authority to allow masters trained behavioral health providers (e.g., licensed professional counselors, mental health counselors, or marital and family therapists) to be RHC practitioners for purposes of Medicare reimbursement if they are licensed to provide those services in their state.

Lab Requirements

The Rural Health Clinic Services Act of 1977 describes the RHC lab requirement in the following way: “directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title.”¹⁷ These requirements can lead to inefficiencies in certain situations, such as pregnancy testing requirements for pediatric facilities or the hematocrit requirement.

Recommendation 6: The Committee recommends the Secretary publish a Request for Information to RHC providers on current RHC laboratory needs. Based on this information, the Committee recommends the Secretary use the authority granted in Public Law 95-210 to review and modernize lab requirements to reduce regulatory burden and allow flexibility in requirements to reflect patient population services.

OTHER CONSIDERATIONS

While hearing from federal and state health and human service officials and participating in discussions with various RHC providers during our site visit, many different challenges were

brought to the Committee's attention. While the Committee has chosen to address and provide recommendations to the Secretary on only for those challenges listed above, the Committee would like to spotlight other challenges mentioned that merit further consideration from HHS in order to fully modernize the RHC provisions. In addition, the Committee believes these issues would help reduce burden on providers in alignment with the Department's ongoing efforts to reduce regulatory burden across the Medicare program.

Commingling Reform

Commingling is “the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners.”¹⁸ Prohibition of commingling ensures the prevention of duplicate Medicaid or Medicare reimbursement and prevents RHCs from selectively choosing higher or lower reimbursement rates. However, the necessary steps that must be taken to help distinguish costs can create inefficiencies, unnecessary burden, and disruption of timely access to care for RHC patients. The added burden of reviewing commingling in the survey process creates additional challenges for providers and is often inconsistent from one region to the other. RHC stakeholders recommended certain changes to the Medicare cost report as a step towards alleviating the burden of commingling requirements. As HHS continues to focus on reviewing regulatory burden challenges, the Committee believes there are opportunities to streamline and improve ensuring program compliance for RHCs related to commingling issues.

Survey/Certification Delays

RHC stakeholders also told the Committee that delays in surveys and certification create particular challenges for new RHCs. One hospital stakeholder told the Committee about delays in opening a provider-based RHC in Idaho and that created delays in billing, affecting the financial viability of the hospital. The Committee recognizes that the ability to do timely surveys and to certify clinics may be more of a budget issue for HHS than a policy issue.

Location Requirements

The Committee received feedback from RHC stakeholders that HHS could provide additional clarity on re-location requirements. Several provided examples of situations in which RHCs have moved to new facilities in the same town, but found themselves at risk of either no longer being in a non-urbanized area or no longer in a HPSA. A few of the RHCs present said they had chosen not to move to larger or more modern locations nearby that would have better served their patients due to concerns of running into similar challenges. In alignment with HHS's focus on reducing regulatory burden for providers, there may be an opportunity for the Department to explore options for providing more regulatory flexibility in handling these situations so services are not disrupted and providers are not locked into a physical location that might not be best for patient care.

Employment Requirements

RHC providers expressed concern regarding the statutory requirement related to the amount of time certain providers must be present and the interpretation of the term “employ” within the requirements.^f RHC stakeholders indicated finding a PA or NP to work at least 50 percent of the

^f Employment requirements are currently framed as: “RHCs must employ a NP or PA (RHCs may contract with NPs, PAs, CNMs, CPs, and CSWs when at least one NP or PA is employed by the RHC)”

time has been a challenge and in some cases, an MD specializing in family medicine would be interested in opening a clinic, but cannot find a PA or NP to also work in the clinic. Another related challenge is the requirement to employ a PA or NP full- or part-time as evidenced by a W-2 form. This has also been a burden for RHCs that may have difficulty recruiting a full-time or part-time PA or NP as a W-2 employee, but may be able to fulfill this requirement by contracting instead with a PA or NP. In 2014, HHS did add some flexibility to this requirement by allowing RHCs to “contract with non-physician practitioners (PAs, NPs, CNM, CPs or CSWs) as long as at least one NP or PA is employed by the RHC.”¹⁹ While this added flexibility was helpful, the Committee suggests the flexibility be expanded to reflect a variety of appropriate employment arrangements, as direct hiring may be restrictive for RHCs. This added flexibility was a step in the right direction, but should be expanded to reflect that there are a variety of appropriate employment arrangements and direct staffing may be restrictive for RHCs. Another expansion could include allowing other appropriately licensed health care providers (as determined by each state), in addition to physicians, PAs, NPs, CNMs, CPs, and CSWs, to be eligible to fulfill the employment requirements.

CONCLUSION

This brief summarizes the Committee’s learning from the September 2017 meeting about the challenges RRHCs face in today’s health care environment. Throughout the meeting, the Committee considered both how RHC providers can adapt to better participate in a value-based delivery system and how RHC policies and regulations can change to better accommodate rural patients and communities. This memo outlined initial steps that department could take to modernize RHC provisions through the regulatory process, as well as suggestions that would require legislative action.

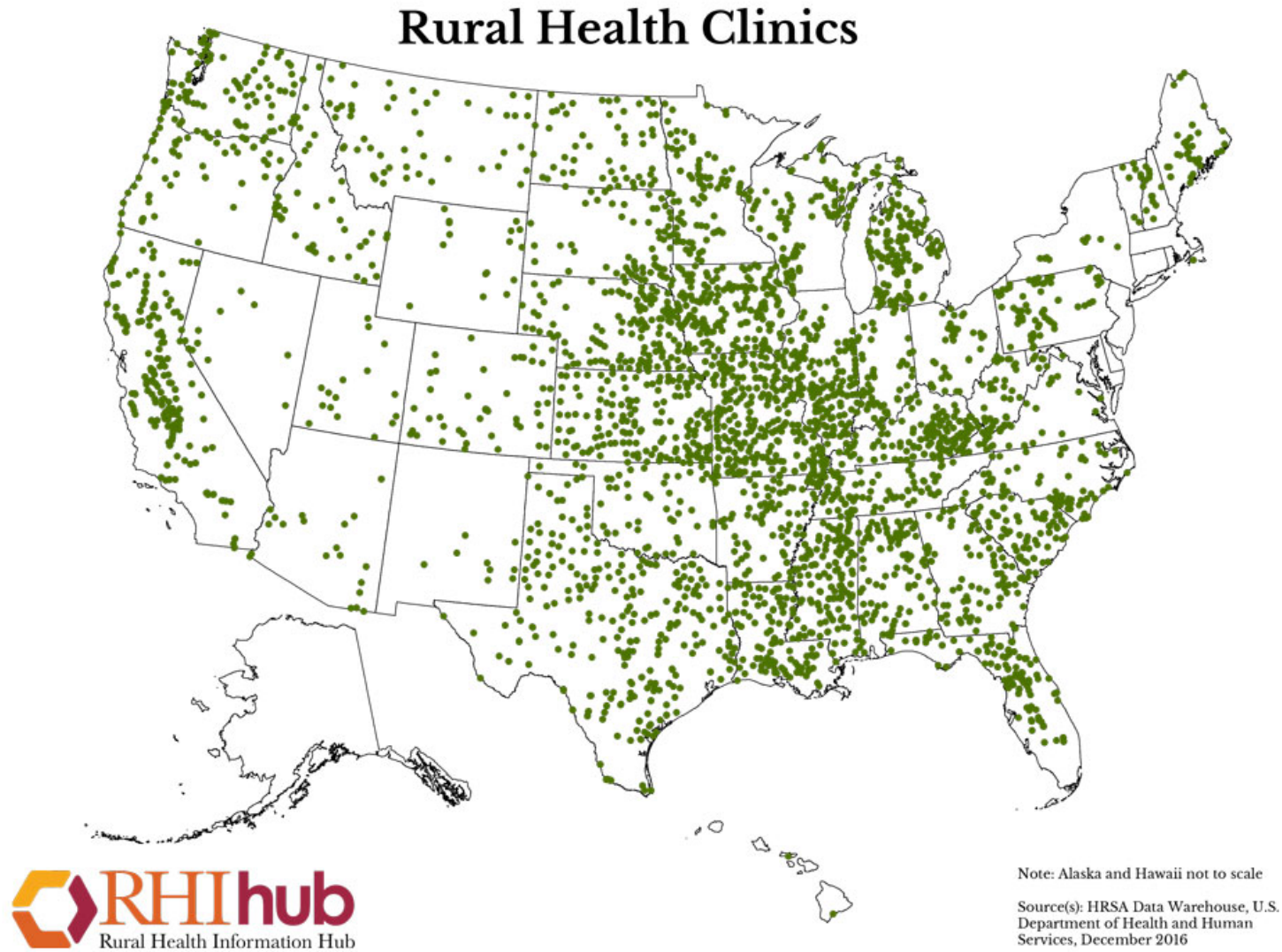
APPENDICES

A. Rural Health Clinic Map

B. Site Visit Profiles

- North Canyon Medical Center/North Canyon Family Physicians
- Associates in Family Practice
- Shoshone Family Medical Center
- Power County Hospital District

Appendix A: Rural Health Clinic Map



RHIhub. (2016, December). Rural Health Clinics. Retrieved October 03, 2017, from <https://www.ruralhealthinfo.org/resources/987>

Appendix B: Site Visit Profiles

While our site visit was physically held at North Canyon Medical Center in Gooding, ID, several other RHC providers were invited to participate in the discussion. RHCs from Gooding, Power, and Lincoln Counties were represented. Costs and financial burdens were common issues for the RHCs. Many of these concerns surrounded the cost of staffing, cost of electronic medical record systems, and the time between up-front costs and receiving payment.

North Canyon Medical Center/North Canyon Family Physicians

North Canyon Medical Center is located in Gooding, Idaho, in the south central area of the state and is a CAH. North Canyon Family Physicians, previously Gooding Family Physicians, merged with North Canyon Medical Center in 2014. This move transformed the practice from an independent RHC to a provider-based RHC. They noted that this status is the only way they could survive financially and is what led to them merging with North Canyon Medical Center. A doctor associated with this RHC expressed his desire for access to the broader services of the medical center and said the transition to being a provider-based RHC, in this situation, made referrals easier and it was better for patient care.

Associates in Family Practice

Associates in Family Practice has three independent RHCs in Gooding County. They have eight providers total that rotate through the three offices. Of these eight providers, four are doctors. They estimate they see approximately 15-20 patients per day, per provider across their locations. Recently, they had to take out a short-term loan in order to cover the costs of vaccines until the cost report is settled. This was a struggle for them because it takes almost a year from the time they pay for things and when they file their cost report to get paid/reimbursed. They expressed a desire for a higher payment cap to allow them to help cover more of the actual costs that are incurred, but also to allow them to address more issues in one visit with patients. Handling more than one issue per session is particularly important for rural areas where long distances may inhibit regular health care and follow-up visits.

Shoshone Family Medical Center

Shoshone Family Medical Center, an independent RHC, is the only health care facility in Lincoln County. Lincoln County has a population of approximately 6,000 and Shoshone Family Medical Center serves a patient population of approximately 4,000. Providers currently see 50-60 patients a day in a facility built in 1910 with five exam rooms. Shoshone Family Medical Center representatives expressed feeling limited by their inability to expand and move locations for fear of losing their RHC status. While staff members reported feeling empowered by the doctor to take on extra costs and go the extra mile for patients, they did feel limited by the payment cap and the inability to collect payment for any extra time spent with patients. Overall, they expressed concern that three of the greatest limiting factors for RHCs are time, people, and capital.

Power County Hospital District

The Power County Hospital District provides residents of the county access to a CAH and a provider-based RHC. Certification was a significant barrier for the hospital district. Wait times for certification can often be as long as 90 – 120 days, so they often take on the cost until approved as an RHC. With tight budgets and the previously mentioned financial concerns faced by many RHCs, these costs are not easy for them to carry. Technical costs for telehealth was also mentioned as a challenge, but having the required separate space for these services presented a bigger problem for them. They did express the opinion that providing these services was valuable, and said consultative telehealth services with local doctors can also be very helpful.

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